

## **1.0 Description of the Service**

This service refers specifically to TB control and treatment in the local health department setting. Service includes medical history on initial visit, update of history on follow-up visits, diagnostic exam, which may include x-rays and laboratory tests, evaluation of current status, treatment for disease and/or prevention, and referral as appropriate.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

### **2.2 Special Provisions**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at <http://www.dhhs.state.nc.us/dma/prov.htm>.

## **3.0 When the Service is Covered**

Services are covered when they are medically necessary.

## **4.0 When the Service is Not Covered**

This service is not covered when the medical criteria listed in **Section 3.0** are not met.

- TB skin testing is not covered for job or college requirements.
- Services of an experimental nature or part of a clinical trial are not covered.

## **5.0 Requirements for and Limitations on Coverage**

Limitations are listed in **Section 8.0, Billing Guidelines**.

## 6.0 Providers Eligible to Bill for the Service

The following providers in a local health department setting are eligible to perform this service.

- physicians
- nurse practitioners
- physician assistants
- public health nurses (RNs) supervised by the public health nurse (RN) who is responsible for the TB Control Program and who has completed the *Introduction to Tuberculosis Management* course

## 7.0 Additional Requirements

Documentation must include:

- medical necessity
- all components of service
- service time component

## 8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in the Medicaid Managed Care programs.

### 8.1 Claim Type

CMS-1500 (HCFA-1500)

### 8.2 Diagnosis Codes That Support Medical Necessity

Providers must bill the most specific diagnosis to support medical necessity.

### 8.3 Procedure Code(s)

Public health nurses use HCPCS code T1002 - "RN services up to 15 minutes." This code is billable when all of the service components are provided. A maximum of 4 units per day may be billed.

Reimbursement for additional units is considered when documentation supports medical necessity. When additional units deny, request an adjustment using the Medicaid Claim Adjustment Request form and include the medical indication (allergic reaction to treatment, STD and TB visit for the same client on the same date of service, history of false positive complicating treatment, comorbid conditions) with documentation. A corrected claim should not be submitted. EDS will perform the adjustment using the adjustment form and the original claim.

T1002 cannot be billed with a preventive medicine, prenatal or treatment code. When another health department provider sees the recipient on the same date of service for a separately identifiable medical condition, the health department may bill the appropriate E/M code. The diagnosis on the claim form must indicate the separately identifiable medical condition.

Bill laboratory codes for laboratory tests done on site.

All other providers billing for these services when provided in health departments must use appropriate E/M codes.

#### **8.4 Reimbursement Rate**

Providers must bill their usual and customary rates.

### **9.0 Policy Implementation/Revision Information**

**Original Effective Date:** October 1, 2002

#### **Revision Information:**

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
12/01/03	Section 4.0	The sentence “This service is not covered when the medical criteria listed in Section 3.0 are not met.” was added to this section.
12/01/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
12/01/03	Section 6.0	A sentence was added to the section stating that providers must comply with Medicaid guidelines and obtain referrals where appropriate for Managed Care enrollees.
12/01/03	Section 8.0	Subsection numbers were added to the subsection titles.
12/01/03	Section 8.0	Subsection 8.4, Reimbursement Rate, was added to the section.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	The sentence stating that providers must comply with Medicaid guidelines and obtain referral where appropriate for Managed Care enrollees was moved from Section 6.0 to Section 8.0.
12/1/05	Section 2.2	The web address for DMA’s EDPST policy instructions was added to this section.